FORM 1:
NOTIFICATION CARD

For Office Use Only	
Date on which notification was received	
Name of the person who received the notification	

Instructions:

1. *To be filled by the Primary informant*
2. *Two copies should be filled in case of CBCDR (one to be submitted to ANM and one handed over to the family)*
3. *For FBCDR only one copy needs to filled and handed over to FNO*
4. *If the notification card is already filled, address the bereavement issues, offer support and leave (CBCDR only)*
5. *Write in capital letters*
6. *Circle the appropriate response (or) place a √ (tick) wherever applicable*

1. Name of the Child : ______________________________
   (In case of a newborn, name of the mother should be used. eg: Baby of Nirmala)
2. Date of Birth (if available) D D / M M / Y Y Y Y
3. Age: ☐☐ Years ☐☐ Months ☐☐ Days ☐☐ Hours
3. Sex: ☐ Male ☐ Female
4. Mother's Name : ______________________________
5. Father's Name : ______________________________
6. Complete Address : ______________________________
   House Number : ______________________________
   Mohalla/Colony : ______________________________
   Village/Town/City : ______________________________
   Block : ______________________________
   District/Tehsil : ______________________________
   State : ______________________________
   Pincode : ☐☐☐☐☐☐
7. Landmarks, if any : ______________________________

8. Phone number of parents/family member (living in same household):

☐ Landline: ______________________________

☐ Mobile Number: ___________________________

9. Date of Death: D D / M M / Y Y Y Y

10. Place of Death:

a) Home ☐ b) Hospital ☐ **(If hospital, mention the name __________)**

c) In transit ☐

Name of First Informant ______________________________**Time** __________

Signature ________________ **Date of Notification**__________

Hand over this card to the parents of the child. The purpose is to provide verification of the fact that the family has been visited by the primary informant, and to inform others (the informant/s) visiting the family subsequently that the death has already been informed and to not repeat the process

Dear Parents,

We express our profound grief on the loss of your child. We will like to know more from you about the factors that could have contributed to the death of your baby so that steps can be taken to prevent such deaths in the future. In this context, some of health staff members may visit you in coming weeks.

You are requested to please retain all the documents pertaining to the health condition of the baby and the mother.

Please show this card to the health staff, who comes to collect further details about the illness.

Signature of the Informant

Designation______________

Date______/______/________

FORM 2:
FIRST BRIEF INVESTIGATION REPORT

Instructions:

1. *To be filled by the ANM*
2. *Write in capital letters*
3. *Circle the appropriate response (or) place a √ (tick) wherever applicable*

Section A. Background Information

1. Name of the Child : ______________________
2. Date of Birth (if available) [D][D] / [M][M] / [Y][Y][Y][Y]
3. Age: [ ] Years [ ][ ] Months [ ][ ] Days (if age less than 1 month)
   [ ][ ] Hours (if age less than one day)
4. Sex: [ ] Male [ ] Female
5. Address: ______________________
6. Name of Area PHC ______________________
7. Name of Area Sub-center ______________________
8. Order of Birth: [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 or more
9. Belongs to: SC/ ST [ ] OBC [ ] General [ ]
10. Does the family have a Below Poverty Line (BPL) card: Yes [ ] No [ ]
11. Immunization Status:
    BCG [ ] DPT 1 [ ] DPT 2 [ ] DPT 3 [ ] Measles [ ] Measles Booster [ ]
    HiB 1 [ ] HiB 2 [ ] HiB 3 [ ]
12. Weight (if recorded in the MCP card): [ ][ ] . [ ][ ] Kg
13. Growth Curve (fill for child less than 3 years; check MCP card):
    a. Green zone [ ] b. Yellow Zone [ ] c. Orange Zone [ ]
14. Any h/o illness/injury: Yes [ ] No [ ] **(if No, go to Sec. B)**
15. If yes, nature of illness: [ ]

16.	Symptoms during illness	Circle the app. response	If Yes,Duration of symptoms
a.	Inability to feed	Yes/No	☐☐ days
b.	Fever	Yes/No	☐☐ days
c.	Loose stools	Yes/No	☐☐ days
d.	Vomiting	Yes/No	☐☐ days
e.	Fast breathing	Yes/No	☐☐ days
f.	Convulsions	Yes/No	☐☐ days
g.	Appearance of Skin rashes	Yes/No	☐☐ days
h.	Injury (like fractures, wounds)	Yes/No	☐☐ days
i.	Any other symptom (if yes) specify	Yes/No	☐☐ days

17. Details of treatment:

1) Whether treatment for illness was taken or not? Yes ☐ No ☐ **(if No, go to sec. B)**

2) If yes, where was the child treated:

a. Public Health Facility: PHC ☐ CHC ☐ DH ☐ SDH/Taluq Hospital ☐

b. Private Hospital/Nursing Home ☐

c. Qualified allopathic private practitioner ☐

d. AYUSH practitioner ☐

e. Unqualified provider (quack, informal provider) ☐

f. Traditional healer ☐

Section B. Probable cause of death:

a. Diarrhoea ☐ b. Pneumonia ☐ c. Malaria ☐

d. Measles ☐ e. Septicemia (Infection) ☐ f. Meningitis ☐

g. Injury ☐ h. Any other cause (specify) .... ☐

i. No identifiable cause ☐

Section C. According to the respondent (parent, close family member), what was the cause of death?

Section D. At which level do you think the delay occurred?

1. **Delay at home** (eg; seriousness of illness not recognized, treatment not sought, treatment sought at a late stage, family members did not allow treatment seeking) ☐
2. **Delay in transportation** (eg; transport facility not available, could not afford local transport, difficult/hilly terrain, long distance to the health facility) ☐
3. **Delay at facility level** (eg; doctor/staff not available, drugs & equipment not available, delay in initiation of treatment) ☐

Section E. Based on your analysis of the situation in which the death took place, what according to you could have been done to avert this death?

1. ______________________________

2. ______________________________

3. ______________________________

Name of ANM..............................

Signature..............................

Health Centre..............................

Date......................................

FORM 3a:
VERBAL AUTOPSY FORM: NEONATAL DEATHS

Instructions

1. NOTE: This form must be completed for all neonatal deaths (0-28 days).

2. Write in capital letters

3. Circle the appropriate response (or) place a √ (tick) wherever applicable

District: .... **Block:** .... **Village:** ....

PHC: .... **Sub-Centre:** ....

MCTS Number: .... **Date:** ..../........../...............

Name of Head of the Household:																
Full name of the deceased:																
Name of mother of deceased:																

Section A: Details for Respondent and Deceased

Details of the Respondent:

1.	Name of the respondent				
2.	Relationship of the respondent with the deceased:				
a. Brother/Sister	☐	b. Mother/Father	☐	c. Neighbour/No relation	☐
d. Grandfather/Grandmother	☐	e. Other relative	☐		
3.	Did the respondent live with the deceased during the events that led to death?				
a.	Yes ☐	b.	No ☐		
4.	What is the highest standard of education the respondent has completed?				
a.	Illiterate and literate with no formal education: ☐				
b.	Literate, Primary or below ☐	c.	Literate, Middle ☐	d.	Literate, Matric (Class-X) ☐
e.	Literate, Class XII ☐	f.	Graduate & above ☐		
5.	Category: a. SC/ST ☐	b. OBC ☐	c. General ☐		
6.	Religion of the head of the household				
a. Hindu ☐	b. Muslim ☐	c. Christian ☐	d. Sikh ☐		
e. Buddhist ☐	f. Jain ☐	g. No religion ☐	h. Others, Specify.......... ☐		

Details of deceased

7.	Deceased's Sex:	a. Male ☐	b. Female ☐
8.	Age in completed days:	a. Less than 1 day ☐	b. 01-28 days ☐
9.	Date of birth:	D D / M M / Y Y Y Y	
10.	Date of death:	D D / M M / Y Y Y Y	
11A	House address of the deceased:		
11B	PIN:		

12.	Place of death:				
a. Home ☐	b. On way to health facility/in transit ☐	c. Sub Center ☐			
d. PHC/CHC/Rural Hospital ☐	e. District Hospital ☐	f. Medical College ☐			
g. Private Hospital ☐	h. Other, Specify........................ ☐	i. DNK ☐			

Section B: Neonatal Death

13A.	Did the child met with an accident				
a.	Yes ☐	b.	No ☐ **(if No, go to Q 14A)**		
13B.	If yes, what kind of injury or accident?				
a.	Road traffic injury ☐	b.	Falls ☐	c.	Fall of objects ☐
d.	Burns ☐	e.	Drowning ☐	f.	Poisoning ☐
g.	Bite/sting ☐	h.	Natural disaster ☐	i.	Homicide/assault ☐
x.	Other, Specify ________________________ ☐				
13C.	Do you think the child died from an injury or accident				
a.	Yes ☐ **(if Yes, go to Section C)**	b.	No ☐	c.	DNK ☐

Details of pregnancy and delivery:

14A	How many months long was the pregnancy? ☐ (in completed months)				
14B	Mother's age: D D / M M / Y Y Y Y				
15	Did the mother receive 2 doses of tetanus toxoid during pregnancy?				
a.	Yes ☐	b.	No ☐	c.	DNK ☐
16A	Were there any complications during the pregnancy, or during labour?				
a.	Yes ☐	b.	No ☐ **(go to Q 17)**	c.	DNK ☐ **(go to Q17)**
16B	If yes, what complication(s) occurred? **(Check all that apply)**				

a. Mother had fits ☐
b. Excessive (more than normal) bleeding before/during delivery ☐
c. Water broke one or more days before contractions started ☐
d. Prolonged/difficult labour (12 hours or more) ☐
e. Operative delivery (C - Section) ☐
f. Mother had fever ☐
g. Baby had cord around neck ☐
h. Instrumental Delivery/Assisted ☐
i. DNK ☐

17.	Was the child a single or multiple birth?				
a.	Single ☐	b.	Multiple ☐	c.	DNK ☐
18.	Where was s/he born?				

a. Home ☐	b. On way to health facility/in transit ☐	c. Sub Center ☐
d. PHC/CHC/Rural Hospital ☐	e. District Hospital ☐	f. Medical College ☐
g. Private Hospital ☐	h. Other, Specify........................ ☐	i. DNK ☐

19.	Who attended the delivery?				
	a. Untrained traditional birth attendant		b. Trained traditional birth attendant		
	c. ANM/Nurse		d. Allopathic Doctor		e. Other, Specify..................
	f. None		g. DNK		
20.	Was a disinfected or new knife/blade used to cut the umbilical cord?				
a.	Yes	b.	No	c.	DNK
21.	Was it a live/still birth:	a.	Live birth	c.	Still birth (go to Section C)
Details of baby after birth					
22.	Did the baby ever cry, move or breath?				
a.	Yes	b.	No	c.	DNK
23.	Were there any bruises or signs of injury on child's body after the birth?				
a.	Yes	b.	No	c.	DNK
24A.	Did baby had any visible malformations at birth?				
a.	Yes	b.	No	c.	DNK
24B.	Compared to other children in your area, what was the child's size at birth?				
a.	Very small	b.	Smaller than average	c.	Average
d.	Larger than average	e.	DNK		
24C.	What was the birth weight?				
a.	Kgs .	b.	DNK		
25A.	Did baby stop crying after some time? (Denoting any illness)				
a.	Yes	b.	No **(go to Q 26A)**	c.	DNK **(go to Q 26A)**
25B.	If yes, how many days after birth did baby stop crying?				
a.	$\leq$ 1 day	b.	days		
26A.	When was baby first breastfed?				
a.	Immediately/within one hour of birth	b.	Same day child was born		
c.	Second day or later	d.	Never breastfed (go to Q 27A)		
e.	DNK				
26B.	Was baby able to suckle normally during the first day of life?				
a.	Yes	b.	No (go to Q 27A)	c.	DNK (go to Q 27A)
26C.	If yes, did baby stop being able to suck in a normal way?				
a.	Yes	b.	No (go to Q 27A)	c.	DNK (go to Q 27A)
26D.	If yes, how many days after birth did baby stop sucking?				
a.	$\leq$ 1 day	b.	days		
27A.	Was the baby ever given anything to drink other than breast milk?				
a.	Yes	b.	No (go to Q 28A)	c.	DNK (go to Q 28A)
27B.	If yes what was given (specify) ______________________				
	a. Frequency per day		b. DNK		

Details of sickness at the time of death								
28A.	Did baby have fever?							
a.	Yes	☐	b.	No ☐ (go to Q 29A)	c.	DNK ☐ (go to Q 29A)		
28B.	If yes, how many days did the fever last?							
a.	≤ 1 day	☐	b.	☐☐ days				
29A.	Did baby have any difficulty in breathing?							
a.	Yes	☐	b.	No ☐ (go to Q 30A)	c.	DNK ☐ (go to Q 30A)		
29B.	If yes, for how many days did the difficulty with breathing last?							
a.	≤ 1 day	☐	b.	☐☐ days				
30A.	Did baby have fast breathing?							
a.	Yes	☐	b.	No ☐ (go to Q 31A)	c.	DNK ☐ (go to Q 31A)		
30B.	If yes, for how many days did the fast breathing last?							
a.	≤ 1 day	☐	b.	☐☐ days				
31.	Did baby have in-drawing of the chest?							
a.	Yes	☐	b.	No ☐	c.	DNK ☐		
32A.	Did baby have a cough?							
a.	Yes	☐	b.	No ☐	c.	DNK ☐		
32B.	Did baby have grunting (demonstrate)?							
a.	Yes	☐	b.	No ☐	c.	DNK ☐		
32C.	Did baby's nostrils flare with breathing?							
a.	Yes	☐	b.	No ☐	c.	DNK ☐		
33A.	Did baby have diarrhoea (frequent liquid stools)?							
a.	Yes	☐	b.	No ☐ (go to Q 34A)	c.	DNK ☐ (go to Q 34A)		
33B.	If yes, for how many days were the stools frequent or liquid?							
a.	≤ 1 day	☐	b.	☐☐ days				
34A.	Did baby vomit?							
a.	Yes	☐	b.	No ☐ (go to Q 35A)	c.	DNK ☐ (go to Q 35A)		
34B.	If yes, for how many days did baby vomit?							
a.	≤ 1 day	☐	b.	☐☐ days				
35A.	Did baby have redness around, or discharge from, the umbilical cord stump?							
a.	Yes	☐	b.	No ☐	c.	DNK ☐		
36.	Did baby have yellow eyes or skin?							
a.	Yes	☐	b.	No ☐	c.	DNK ☐		
37.	Did baby have spasms or fits (convulsions)?							
a.	Yes	☐	b.	No ☐	c.	DNK ☐		
38.	Did baby become unresponsive or unconscious?							
a.	Yes	☐	b.	No ☐	c.	DNK ☐		
39.	Did baby have a bulging fontanelle (describe)?							
a.	Yes	☐	b.	No ☐	c.	DNK ☐		
40.	Did the child's body feel cold when touched?							
a.	Yes	☐	b.	No ☐	c.	DNK ☐		
41.	Were the child's hands, legs or lips discoloured (blue, other colour)?							
a.	Yes	☐	b.	No ☐	c.	DNK ☐		

42.	Did s/he have yellow Palms/soles?				
a.	Yes ☐	b.	No ☐	c.	DNK ☐
43.	Was there blood in the stools?				
a.	Yes ☐	b.	No ☐	c.	DNK ☐

Section C: Written narrative in local language

44. Please describe the symptoms in order of appearance, doctor consulted or hospitalization, history of similar episodes, enter the results from reports of the investigations if available. (use additional sheets if required)

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45. What did the respondent think the newborn died of? (Allow the respondent to tell the illness in his or her own words)

Interviewer's Signature: .... Interviewer Name: .... Designation: .... Date: ..../........./....................	Signature/Left thumb Impression of respondent

Assigned cause of death*

**Assigned at district level*
DNO will have to communicate the assigned cause of death to respective block

FORM 3b:
VERBAL AUTOPSY FORM: POST-NEONATAL DEATHS

Instructions

1. NOTE: This form must be completed for all post-neonatal deaths (29 days - 5 years).
2. Write in capital letters
3. Circle the appropriate response (or) place a √ (tick) wherever applicable

District: .... **Block:** .... **Village:** ....

PHC: .... **Sub-Centre:** ....

MCTS Number: .... **Date:** ..../........../...............

Name of Head of the Household: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Full name of the deceased: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Name of mother of deceased: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Section A: Details for Respondent and Deceased

Details of the Respondent:

1.	Name of the respondent ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
2.	Relationship of the respondent with the deceased:

a. Brother/Sister ☐ b. Mother/Father ☐ c. Neighbour/No relation ☐
d. Grandfather/Grandmother ☐ e. Other relative ☐

3.	Did the respondent live with the deceased during the events that led to death?				
a.	Yes ☐	b.	No ☐		
4.	What is the highest standard of education the respondent has completed?				
a.	Illiterate and literate with no formal education: ☐				
b.	Literate, Primary or below ☐	c.	Literate, Middle ☐	d.	Literate, Matric (Class-X) ☐
e.	Literate, Class XII ☐	f.	Graduate & above ☐		
5.	Category: a. SC/ST ☐ b. OBC ☐ c. General ☐				
6.	Religion of the head of the household				

a. Hindu ☐ b. Muslim ☐ c. Christian ☐ d. Sikh ☐
e. Buddhist ☐ f. Jain ☐ g. No religion ☐ h. Others, Specify.......... ☐

Details of deceased

7.	Deceased's Sex: a. Male ☐ b. Female ☐
8.	Age in completed days: a. 29 days - 1 Year ☐ b. 01-05 Years ☐
9.	Date of birth: D D / M M / Y Y Y Y
10.	Date of death: D D / M M / Y Y Y Y
11A	House address of the deceased:
11B	PIN: ☐☐☐☐☐☐

12	Place of death:				
a. Home ☐		b. On way to health facility/in transit ☐		c. Sub Center ☐	
d. PHC/CHC/Rural Hospital ☐		e. District Hospital ☐		f. Medical College ☐	
g. Private Hospital ☐		h. Other, Specify........................ ☐		i. DNK ☐	

	Section B: Post-Neonatal Death				
13A.	Did the child met with an accident				
a.	Yes ☐	b.	No ☐ **(if No, go to Q 14A)**		
13B.	If yes, what kind of injury or accident?				
a.	Road traffic injury ☐	b.	Falls ☐	c.	Fall of objects ☐
d.	Burns ☐	e.	Drowning ☐	f.	Poisoning ☐
g.	Bite/sting ☐	h.	Natural disaster ☐	i.	Homicide/assault ☐
x	Other, Specify ____________________ ☐				
13C.	Do you think the child died from an injury or accident				
a.	Yes ☐ **(go to Section C)**	b.	No ☐	c.	DNK ☐

Details of child after birth			
14A.	When was child first breastfed?		
a.	Immediately/within one hour of birth ☐	b.	Same day child was born ☐
c.	Second day or later ☐	d.	Never breastfed ☐
e.	DNK ☐		

14B.	Did the child receive any feed other than breast milk during the first 6 months of life?				
a.	Yes ☐	b.	No ☐	c.	DNK ☐
14C.	During the illness that led to death, was the child breastfeeding? (if child less than 18 months)				
a.	Yes ☐	b.	No ☐	c.	DNK ☐

Details of sickness at time of death					
15A.	Did the child had fever?				
a.	Yes ☐	b.	No ☐ **(go to Q16)**	c.	DNK ☐ **(go to Q16)**
15B.	If yes, how many days did the fever last?				
a.	≤ 1 day ☐	b.	☐☐ Days		
15C.	Was the fever accompanied by chills/rigors?				
a.	Yes ☐	b.	No ☐	c.	DNK ☐
16.	Did the child have convulsions or fits?				
a.	Yes ☐	b.	No ☐	c.	DNK ☐
17.	Was the child unconscious during the illness that led to death?				
a.	Yes ☐	b.	No ☐	c.	DNK ☐
18.	Did the child develop stiffness of the whole body?				
a.	Yes ☐	b.	No ☐	c.	DNK ☐
19.	Did the child have a stiff neck (demonstrate)?				
a.	Yes ☐	b.	No ☐	c.	DNK ☐

20A.	Did the child have diarrhoea (more frequent or more liquid stools)?				
a.	Yes ☐	b.	No ☐ **(go to Q21A)**	c.	DNK ☐ **(go to Q21A)**
20B.	If yes, for how many days?				
a.	≤ 1 day ☐	b.	☐☐ Days		
20C.	Was there blood in the stools?				
a.	Yes ☐	b.	No ☐	c.	DNK ☐
21A.	Did the child have a cough?				
a.	Yes ☐	b.	No ☐ **(go to Q22A)**	c.	DNK ☐ **(go to Q22A)**
21B.	If yes, for how many days?				
a.	≤ 1 day ☐	b.	☐☐ Days		
21C	If yes, was there blood?				
a.	Yes ☐	b.	No ☐	c.	DNK ☐
22A.	Did the child have breathing difficulties?				
a.	Yes ☐	b.	No ☐ (if no go to Q22C)	c.	DNK ☐ **(go to Q22C)**
22B.	If yes, for how many days?				
a.	≤ 1 day ☐	b.	☐☐ Days		
22C.	Did the child have fast breathing?				
a.	Yes ☐	b.	No ☐	c.	DNK ☐
22D.	Did the child have in-drawing of the chest?				
a.	Yes ☐	b.	No ☐	c.	DNK ☐
22E.	Did the child have wheezing (demonstrate sound)?				
a.	Yes ☐	b.	No ☐	c.	DNK ☐
23A.	During the illness, did child have abdominal pain?				
a.	Yes ☐	b.	No ☐	c.	DNK ☐
23B.	Did the child have abdominal distention?				
a.	Yes ☐	b.	No ☐	c.	DNK ☐
24A.	Did the child vomit?				
a.	Yes ☐	b.	No ☐ **(if no go to Q25)**	c.	DNK ☐ **(go to Q25)**
24B.	If yes, for how many days?				
a.	≤ 1 day ☐	b.	☐☐ Days		
25.	Did the eye/skin colour change to yellow				
a.	Yes ☐	b.	No ☐	c.	DNK ☐
26A.	Was the rash all over the body?				
a.	Yes ☐	b.	No ☐	c.	DNK ☐
26B.	Did the child have red eyes?				
a.	Yes ☐	b.	No ☐	c.	DNK ☐
26C.	Was this measles (use local term)?				
a.	Yes ☐	b.	No ☐	c.	DNK ☐

No.	Question / Option				
27.	During the weeks preceding death, did the child become very thin?				
a.	Yes	b.	No	c.	DNK
28.	During the weeks preceding death, did the child have any swelling of hands, feet or abdomen?				
a.	Yes	b.	No	c.	DNK
29.	During the weeks preceding death, did the child suffer from lack of blood or appear pale?				
a.	Yes	b.	No	c.	DNK
30.	Compared to other children of the same age, was child growing normally?				
a.	Yes	b.	No	c.	DNK
31A.	Did the child have multiple illnesses?				
a.	Yes	b.	No **(go to Q32A)**	c.	DNK **(go to Q32A)**
31B.	If yes, what were the symptoms associated with these illnesses? **(Check all that apply)**				
a.	Cough	b.	Diarrhoea	c.	Ear discharge
d.	Fever	e.	Rashes	f.	Other, Specify........
g.	DNK				
32A.	Did the child receive BCG injection?				
a.	Yes	b.	No	c.	DNK
32B.	Number of dozes received of DPT (DPT-3)?				
a.	Yes	b.	No	c.	DNK
32C.	Did the child receive polio drops in the mouth?				
a.	Yes	b.	No	c.	DNK
32D.	Did the child receive an injection for measles (use local term)?				
a.	Yes - only one	b.	Yes - more than one		
c.	No - did not receive any	d.	DNK		

Section C: Written narrative in local language

No.	Question
33.	Please describe the symptoms in order of appearance, doctor consulted or hospitalization, history of similar episodes, enter the results from reports of the investigations if available. **(use additional sheets if required)**

34.	What did the respondent think the newborn died of? (Allow the respondent to tell the illness in his or her own words)

Interviewer's Signature: .... **Interviewer Name:** .... **Designation:** .... **Date:** ..../......../.................	**Signature/Left thumb impression of respondent:**

Assigned cause of death*	

***Assigned at the district level**
DNO will have to communicate the assigned cause of death to the respective block

FORM 3c:
SOCIAL AUTOPSY FORM

Instructions

1. To be filled for all verbal autopsies conducted and attach with the same

2. Write in capital letters

3. Circle the appropriate response (or) place a √ (tick) wherever applicable

4. Attach a copy of the case records to this form.

MCTS number____

Section A: Background Information		
1	Name of key Informant	
2	Relation of key informant to deceased	
3	Place of death of child	
4	Telephone/Mobile Number	
5	Total Number of family members of deceased	
6	Number of children < 5 years	
7	Caste	
8	Do you have Below Poverty Line (BPL) card:	Yes/No
9	What are the Key family Assets: **(Multiple answers allowed. tick all that apply)**	1) Vehicle (motorised) ☐ 2) Television ☐ 3) Own House ☐ 4) Own Land ☐ 5) Cattles ☐ 6) Telephone ☐

Section B: Treatment Seeking History				
10.1	Did ASHA/AWW/VHN/ANM advice on hospital treatment?			
a. Yes ☐	b. No ☐ **(go to Q 11)**	c. DNK ☐ **(go to Q 11)**		
10.2	If Yes, who advised	i. ASHA ☐ ii ANM ☐ iii Link worker ☐ iv Other specify............. ☐		
11	During the illness that led to the death, did you seek care outside the home for the infant?	1) Yes **(Go to Q13)**	2) No	3) DNK
12.	If "NO", then ASK "What were the reasons for not seeking care?"			
12.1	Did not think that the illness was serious	1) Yes	2) No	3) DNK
12.2	Money not available for treatment	1) Yes	2) No	3) DNK
12.3	Family members were not able to accompany	1) Yes	2) No	3) DNK

12.4 Bad weather	1) Yes	2) No	3) DNK
12.5 Did not know where to take the infant	1) Yes	2) No	3) DNK
12.6 No hope for survival of the infant	1) Yes	2) No	3) DNK
12.7 Transport not available	1) Yes	2) No	3) DNK
12.8 Others (specify) **(go to section C)**			

13.	What was the condition of the infant at the time when it was decided for medical consultation? (Tick if any of the condition mentioned in the options is present)	a. Alert/Active/feeding ☐
		b. Conscious but Drowsy/Inactive/ Unable to feed ☐
		c. Unconscious ☐

14	From where or from whom did you seek care?			
14.1	Quack/informal service providers	1) Yes	2) No	3)DNK
14.2	Traditional healer/Religious healer	1) Yes	2) No	3)DNK
14.3	Sub centre	1) Yes	2) No	3)DNK
14.4	PHC	1) Yes	2) No	3)DNK
14.5	CHC	1) Yes	2) No	3)DNK
14.6	Sub-district hospital	1) Yes	2) No	3)DNK
14.7	District (Govt.) Hospital	1) Yes	2) No	3)DNK
14.8	Private allopathic doctor	1) Yes	2) No	3) DNK
14.9	Doctors in alternate system of medicine	1) Yes	2) No	3) DNK
14.10	Reason for seeking care from there: ____________________			

15 Problems faced by the parents in getting treatment in the health facility: Now I will ask you questions related to problems you might have faced in getting the treatment from various health facilities.

	Details	First Health Facility	Referral Institution I	Referral Institution II	Referral Institution III
15.1	Specify in which hospital you took the baby first and then where was the baby taken thereafter? Govt. ______________1 Private ______________2 Not for profit _________3				
15.2	Specify the problem/ complication with which baby was taken to this facility.				
15.3	Total time taken from the onset of the problem to reach this facility **(from home to the facility)**	.... Hours	.... Hours	.... Hours	.... Hours
15.4	Type of treatment received in the institution/hospital				
	NIL				
	First Aid				
	Others (Specify)..				

15.5	Specify the reasons for referring to another institution				
	Lack of Specialists				
	Lack of Equipments				
	Others (Specify)				
15.6	Mode of transport from one institution to other				
15.7	Distance from one facility to other (in kms)	.... Kms	.... Kms	.... Kms	.... Kms
15.8	If baby was taken to any institution other than the one referred, state the reasons				
15.9	If baby was taken to any institution other than the one referred, who advised (eg; caregivers, relatives etc.)				
15.10	Was the child attended immediately Yes _______________1 No _______________2				
15.11	If yes, time taken to initiate treatment in the institution on reaching the hospital	...........Mins	...........Mins	...........Mins	...........Mins
15.12	Reasons for the delay in initiating treatment (Use your judgment in arriving the reasons)				
a.	Doctor not available				
b.	Paramedical workers not available				
c.	Too much patient rush				
d.	Informal payment				
e.	Mobilizing specialists				
f.	Could not afford to pay for the services				
g.	Investigations could not be done				
h.	Other problem (specify)				

16.1 If the baby was shown as having been discharged against medical advice/ absconded, record the reasons for the same.

....

....

....

....

....

....

16.2 Was the discharge due to the dissatisfaction of the treatment given in the hospital? Yes ☐ No ☐ DNK ☐

16.3 What was the states of child at the timed of LAMA/ Discharge. ....

....

....

....

Section C: Brief Social History of the family

17.1	Any history of alcoholism in family	Yes ☐	No ☐	DNK ☐
17.2	Any history of smoking in family	Yes ☐	No ☐	DNK ☐
17.3	Any history of domestic violence in family	Yes ☐	No ☐	DNK ☐

18. Awareness of mother & family members about treatment Seeking

18.1	Do you know the danger signs when a newborn or infant should be taken to health facility?				
a.	Yes ☐		b.	No ☐ **(go to Q18.3)**	
18.2 If yes, what will be the conditions **(don't read the options)**					
a. Pre-term ☐		b. LBW ☐		c. No cry at birth ☐	
d. Fits ☐		e. Difficult breathing ☐		f. Drowsiness/inactivity/unconsciousness ☐	
g. Jaundice ☐		h. Diarrhoea ☐		i. Refusal to feed ☐	
j. Fast Breathing ☐		k. High grade fever ☐			
18.3	Do you know about any hospital where newborns/infants/children can be admitted and treated?				
a.	Yes ☐		b.	No ☐ (go to Q19)	
18.4 If yes, then please name these facilities					

Section D: Expenditure History

19 Can you tell us regarding the total amount that you had to spend on your child?

a. Total amount = Rs.................................
b. Treatment (medicines, consultation, home treatment etc.)....................
c. Transport................................ 3. Others.....................................

20 How did you (the family) arrange this money?	
Multiple answers allowed. Tick all that apply	1. Available/Savings ☐
	2. Borrowed ☐
	3. Sold assets ☐
	4. Community fund ☐
	5. Govt. scheme ☐
	6. Other ☐
	7. Don't know ☐

FORM 5a:
BLOCK AND DISTRICT LEVEL LINE LIST

To be compiled at the block level from the deaths reported by ANMs; at the district level by compilation of reports from all blocks

Name of District: Name of Block: Month: Year:

	Indicators		Case1	Case2	Case3	Case4	....	Total
1.	MCTS ID							
2.	Name							
3.	Mother's name							
4.	Sex	Male_________1						
		Female_______2						
5.	Category	SC/ST________1						
		OBC__________2						
		General______3						
6.	Age	<28 days______1						
		29 days-1 year____2						
		1-5 years___________3						
7.	Village							
8.	PHC area							
9.	Sub-centre area							
10.	Place of birth	Home_____________1						
		Health facility: public_____________2						
		Health facility: private____________3						
		In transit___________4						
11.	Birth weight (Kg)							
12.	Last weight recorded in MCP card (for children < 3 years)							
13.	Immunisation status : complete as per age	Yes___________1						
		No____________2						
14.	Date of death	DD/MM/YYYY						
15.	Place of death (Public Health facility/Private Hospital/Home/in transit)	Home_________1						
		Health facility: private________2						
		Health facility: public_________3						
		In transit_______4						
16.	Probable cause of death							
17.	Level of delay (I/II/III/Multiple levels/Cannot be ascertained)							
18.	Name of the ANM who conducted first brief investigation							
19.	Date on which First Brief Investigation carried out DD/MM/YYYY							
20.	Case selected for Verbal Autopsy	Yes___________1						
		No____________2						
21.	Assigned Cause of death/final diagnosis							

FORM 5b:
DISTRICT LEVEL REPORTING FORM FOR DETAILED INVESTIGATION

Name of District: Name of Block: Month: Year:

	Indicators		Case1	Case2	Case3	Case4	.....	Total
1.	MCTS ID							
2.	Name							
3.	Mother's name							
4.	Sex	Male______ 1						
		Female_____ 2						
5.	Category	SC/ST_______1						
		OBC________2						
		General____3						
6.	Age	<28 days____1						
		29 days-1Year__2						
		1-5 years_____3						
7.	Place of death	Home_________1						
		Health facility: private________2						
		Health facility: public_________3						
		In transit______4						
8.	Detailed Verbal Autopsy report submitted or not	Yes____________1						
		No____________2						
9.	Cause of death/final diagnosis assigned in CBCDR							
10.	Detailed FBCDR conducted (Applicable only for deaths in public health facility)	Yes____________1						
		No____________2						
11.	If yes, cause of death assigned in FBCDR							